STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF SOUTH CAROLINA

The Medicaid Agency Rate Setting Policies, Procedures and Methods for Nursing Facilities, Facilities for the Mentally Retarded, and Long Term Care Institutions for Mental Diseases

I. Cost Finding and Uniform Cost Reports

A) Each nursing facility shall complete and file with the Medicaid Agency, Division of Long Term Care Reimbursements, an annual financial and statistical report supplied by the Medicaid Agency. Effective for the cost reporting period ending September 30, 1996, all nursing facilities will be required to submit their financial and statistical report using the new PACERS (Provider Automated Cost Reporting System) program software provided by the Medicaid Agency. Nursing facilities must report their operations from October 1 through September 30 on a fiscal year basis. Government owned and ICF/MR facilities may report their operations from July 1 through June 30. Hospital based facilities with fiscal year ends other than September 30 will be allowed effective with the 1990 cost reports to use their fiscal year end due to the reporting difficulties of nonconcurrent Medicare and Medicaid fiscal year ends. However, no additional inflation adjustment will be made.

Effective October 1, 1995, nursing facilities which have an annual Medicaid utilization of 1,000 days or less will not be required to file an annual financial and statistical report. However, the provider will be required to submit a working trial balance and patient day utilization information based upon its fiscal year for analytical purposes.

Nursing facilities which incur home office cost/management fees through a related organization are responsible for submitting a hard copy of an annual cost report detailing the cost of the related organization (home office) to the Medicaid Agency. The cost report period should be from October 1 to September 30. However, large chain operations which do business in other states may request a different cost reporting period for their home office cost report; however, no additional inflation adjustment will be made.

B) All nursing facilities are required to detail their cost for the entire reporting period or for period of participation in the plan, if less than the full cost reporting period. These costs are recorded by the facility on the basis of generally accepted accounting principles and the accrual method of accounting. The cash method of accounting is acceptable for public institutions. Effective October 1, 1995, nursing facilities which have an annual Medicaid utilization of 1,000 days or less will not be required to file an annual financial and statistical report. However, the provider will be required to submit a working trial balance and patient day utilization information based upon its fiscal year for analytical purposes.

C) All nursing facilities are required to list the cost of the various services provided under the plan in accordance with the Medicaid Agency's cost reporting format. However, facilities providing services not covered by the plan will be required to use a step down method of cost finding as described in 42 CFR 413.24(d)(1)(1996) to apportion cost between the services covered and the services not covered by the plan before listing the cost of the various services provided under the plan. Services not covered by the plan include, but are not limited to, private pay wings of a facility which participates in the Medicaid (XIX) Program. In regard to stepping down capital related cost and maintenance cost of a private pay wing, the facility must allocate capital related cost (depreciation, interest, etc.) and maintenance cost directly associated with the wing in lieu of using square footage as the statistical base for allocating total capital costs and maintenance costs of the facility. For rates effective January 1, 1988, a facility which participates in the Medicaid program for the first time on and after July 1, 1987 will not be required to prepare a step-down cost allocation if the facility has a private pay wing(s). However, if a facility participating in the Medicaid program for the first time on and after July 1, 1987 adds a private pay wing subsequent to that date, then a step-down allocation of cost as previously described will be required.

D) All nursing facilities are required to report cost on a Uniform Cost Report form provided by the Medicaid Agency. All Uniform Cost Reports must be filed with the Medicaid Agency no later than January 1. However, a thirty (30) day extension of the due date may be granted for good cause. Effective for the cost reporting period ending September 30, 1996, all nursing facilities will be required to submit their financial and statistical report using the new PACERS (Provider Automated Cost Reporting System) program provided by the Medicaid Agency. Due to the implementation of the new PACERS (Provider Automated Cost Reporting System) Program a sixty (60) day extension of the due date may be granted. To request an extension, a written request should be submitted to the Division of Long Term Care Reimbursements prior to the cost report due date. Hospital based/related nursing facility cost reports will be due no later than 30 calendar days after the due date of the hospital's Medicare cost report.

The financial and statistical report shall be certified by the operator of a proprietary medical facility, an officer of a voluntary medical facility, or the public official responsible for the operation of a public medical facility.

A new contract will not be executed until all cost reporting requirements are satisfied. Additionally, if such report properly executed has not been submitted by the required date, the Medicaid Agency shall withhold all funds, or any portion thereof to be determined by the Director, due the Provider until such report is properly submitted and a new contract executed.

Effective October 1, 1995, nursing facilities which have an annual Medicaid utilization of 1,000 days or less will not be required to file an annual financial and statistical report. However, the provider will be required to submit a working trial balance and patient day utilization information based upon its fiscal year for analytical purposes.

E) All nursing facilities are required to retain all financial and statistical records for each cost reporting period, which are accurate and in sufficient detail to substantiate the cost data reported for a period of at least six (6) years following the end of the contract period for which the cost report was used to set this rate. These records must be made available upon demand to representatives of the Medicaid Agency, or the State Auditor, or the United States Department of Health and Human Services. The Medicaid Agency will retain all cost reports for six (6) years after the end of the contract period for which the cost report is used to set the rate. If any litigation, claim, negotiation, or other action involving the records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular six (6) year period, whichever is later.

F) Allowable costs shall include all items of expense which Providers must incur in order to meet the definition of nursing facility services as detailed in 42 CFR 440.40 (1996) and or 440.150 (1996) as promulgated under Title XIX of the Social Security Act, and in order to comply with standards for nursing facility care in 42 CFR 442 (1996) and in order to comply with requirements of the State Agency for establishing and maintaining health standards under the authority of 42 CFR 431.610 (1996) and in order to comply with any other requirements for nursing facility licensing under the State law.

1) Allowable costs are determined in accordance with Title XIX of the Social Security Act, 42 CFR USCA 1396, et seq. and Federal Regulations adopted pursuant to the Act; the Medicaid Agency regulations; Title XVIII of the Social Security Act, 42 CFR USCA 1395 et seq., Federal regulations adopted pursuant thereto and HIM-15, except those provisions which implement Medicare, retrospective, as opposed to Medicaid's prospective, reimbursement system or those provisions which concern the relationship between the provider and Medicare intermediary or are modified by this Plan.

2) Bad debts, charity and courtesy allowance shall not be included in allowable costs except that bad debts that are attributed to cost sharing amounts as defined in 42 CFR 447.50 (1996) and 447.59 (1996) shall be allowable.

3) Allowable cost shall be categorized as follows: (The application is defined in Section III, Payment Determination).

a) Cost Subject to Standards:

i) General Services: Nursing, Social Worker, and Activity Director and related cost.

ii) Dietary

iii) Laundry, Maintenance, and Housekeeping

iv) Administration and Medical Records & Services

b) Cost Not Subject to Standards:

i) Utilities

ii) Special Services

iii) Medical Supplies and Oxygen

iv) Property Taxes and Insurance - Building and Equipment

v) Legal Fees

c) Cost of Capital: The cost of capital reimbursement plan effective July 1, 1989 replaces the prior cost of capital and return on equity policy with one that reimburses costs on the basis of market returns for the current reasonable value of the assets. The plan reduces the wide disparity in the cost of capital payments for basically the same service and makes the cost of capital payment fairer to all participants in the program. The plan also bases reimbursement on investments in facilities of reasonable quality, and does not provide incentives for investment in unnecessarily expensive facilities.

The first step of the plan estimates a reasonable fair market rental value for nursing home beds and assigns each facility a "Deemed Asset Value" based on its number of beds and the fair market rental value of a bed. Secondly, each facility is assigned a "Deemed Depreciated Value" for its assets equal to its Deemed Asset Value less actual accumulated depreciation that the provider has reported in accordance with Medicare/Medicaid guidelines. The next step is to determine a market rate of return that will provide the incentives required to keep the industry growing in step with its needs. A portion of the reimbursement for the cost of capital will be the return on the Deemed Depreciated Value, expressed in terms of patient days.

This cost of capital methodology replaces the prior reimbursement for interest and return on equity. Reimbursement rates for leased facilities are limited to a factor based on the return for the Deemed Depreciated Value of the leased facilities and costs associated with facility leases will not be reimbursed separately. Lease costs associated with equipment rentals (separate from a facility lease) will be reflected in the affected cost centers. Effective October 1, 1993 non-related party home office building rent expense will be classified in the administrative cost center. Depreciation expense applicable to related party home office rental transactions will continue to be classified under cost of capital. The State will continue to provide a reimbursement for actual depreciation based on the original cost of the asset for those facilities put into operation prior to July 1, 1989. A facility's accumulated depreciation will be grandfathered in for that facility in the event of a sale or lease to a new operator. The Deemed Asset Value will be adjusted each year for inflation. The maximum increase that will be allowed will be reflected in the index of home owner's rental value, based on increases in the index of home owner's rental value over the latest three calendar years, as computed by the Division of Research and Statistics of the Budget and Control Board, based on the latest data published by the Bureau of Labor Statistics. However, a lesser amount of inflation may be granted by the Medicaid agency due to compliance with the Medicare upper limits test. For new facilities established or new beds entering the Medicaid Program on and after July 1, 1989, depreciation payments will be set based on actual construction costs, or the Deemed Asset Value when the facility begins operations, whichever is lower, and on applicable Medicare guidelines for depreciation. However, building depreciation for all new facilities/new beds on line on or after July 1, 1991 will be assigned a useful life of 40 years. Accumulated depreciation to be used to offset the deemed asset value for new facilities will be based on accumulated allowed depreciation (i.e. the lesser of actual depreciation or that determined by the Deemed Asset Value).

1) Calculation of Base Period Asset Cost

To avoid the problem of market distortions, this plan selects the average of original costs for facilities established during 1980 and 1981 as the "Original Asset Cost" for determining the fair market rental value for a comparable service during federal cost year 1987-1988. Asset values are those reported by the operators on their original filings. Those two years were the latest prior to the freeze on the value of resales and the limit on interest and depreciation reimbursements. Two years, instead of one, were selected in order to broaden the size of the sample, and to obtain a fairer estimate of the base costs.

Since the return on capital payment is provided as an incentive for the expansion of Medicaid services by the private sector, only those facilities that were established as profit earning centers were selected for the calculation of the base period costs. Non-profit facilities were excluded from the base period calculation.

2) Inflation Adjustment To Current Period "Deemed Asset Value"

The plan uses the index for the rental value of a home computed as part of the CPI as the appropriate measure for approximating the increase in the value of nursing home assets in South Carolina since 1980-1981. This index measures the increase in the amount that homeowners on average could get for renting their homes. For the period from 1980-1981 through the federal cost year 1997-1998, this index rose 124.93 percent.

Inflating the base period market value of $15,618 by the index for homeowner's rent, the "Deemed Asset Value" for cost year 1997-1998 is $35,130 per bed.

3) Calculation of "Deemed Depreciated Value"

The plan will exclude depreciation payments already received by operators from the Deemed Asset Value on the theory that the depreciation charges represent a reasonable valuation of the decline in the worth of the assets from old age. The result is the "Deemed Depreciated Value."

For a facility existing prior to July 1, 1989, the plan will continue to reimburse for actual depreciation costs based on a straight line apportionment of the original cost of the facility and the actual value of any additions. Effective October 1, 1990, for new facilities established or new beds entering the Medicaid Program on and after July 1, 1989, depreciation payments will be set based on actual construction costs, or the Deemed Asset Value when the facility begins operations, whichever is lower, and on applicable Medicare guidelines for depreciation. However, building depreciation for all new facilities/new beds on line on or after July 1, 1991 will be assigned a useful life of 40 years. Accumulated depreciation to be used to offset the deemed asset value for new facilities will be based on accumulated allowed depreciation (i.e. the lesser of actual depreciation or that determined by the Deemed Asset Value).

For bed increases of less than 50% (i.e. no six months cost report is filed), recognition of capital costs will be made at the point in time these beds are certified for Medicaid participation. Furthermore, that portion of the cost of capital reimbursement applicable to these new beds will not be subject to the $3.00 cap.

In order to determine cost of capital reimbursement for these facilities, two cost of capital computations will be completed (for existing and new beds). To determine an equitable capital reimbursement, a formula determination for the new beds utilizing annualized data will be computed and then weighted with the values calculated for the existing beds. The weights will be projected utilization of existing and new beds during the rate cycle, with minimum occupancy being 97%.

The actual cost of any additions to new beds after July 1, 1989 will be added to the Deemed Asset Value for the purpose of computing depreciation charges. For clarification purposes, any capital expenditures incurred after the certification date of the new beds during the initial cost report period will not be considered as improvements, but as part of actual construction costs.

For facilities where there are no historical costs available, the plan computes a Deemed Depreciated Value based on the Base Period Asset Cost, adjusted to the year of construction using the index for home owner's rent, spread over a depreciation period applicable to the year of construction under Medicare guidelines.

The allocation of the base 1981 nursing home bed cost ($15,618) by component is as follows:

Asset Component	Cost Per Bed	Percentage of Total
Land	$ 461	2.95%
Building	12,274	78.59%
Equipment and Other	2,883	18.46%
Total	$15,618	100.00%

A useful life of 40 years will be assigned to the building and a composite useful life of 12 years will be assigned to the equipment and other.

4) Determination of the Market Rate of Return

The plan provides the lowest rate of return to investors that would provide incentives to keep the industry expanding sufficiently to meet the growing needs of Medicaid patients. The industry may need approximately three to four million dollars per year of new investments to keep up with the growing population and the demand for Medicaid services in the near future.

In determining that rate of return, the question is, "where can that money be raised and what rate of return will be necessary to raise that kind of money." Part of the funds could be raised by borrowing from the banks. But this would be rather costly for the small investor, who would probably have to pay a rate of interest in excess of the prime rate.

The plan sets the rate of return for a fiscal year at the average of rates for thirty year treasury bonds for the latest three completed calendar years prior to the fiscal year, as determined by the Division of Research and Statistics of the Budget and Control Board, based on latest data published by the Federal Reserve. Effective October 1, 1999, this rate is 6.3%.

Acknowledging a newly constructed facility's plight of high per bed construction costs and interest rates as great and greater than the market rate of return, the rate of return for these facilities will be the greater of the interest rate incurred by the facility or the industry market rate of return as determined by the Budget and Control Board. These facilities will only be allowed their interest rate (if greater) during a transition period which is defined as the rate period beginning with the facility's entrance into the Medicaid program and ending at that point in time in which the facility files its first annual FYE September 30 cost report that will be used to establish the October 1 rate (i.e. period ends September 30). In no circumstances will the allowed interest rate exceed 3% above the industry market rate of return.

5) Additions To Facilities After 1981

The plan intends to provide adequate incentives for the expansion of nursing home services by the private sector of the state. The Deemed Depreciated Value takes into account the wearing out of facilities, but does not include any factor for additions or upgradings to the facilities. Operators who have made capital improvements to their facilities since 1981 are permitted to add the amount of the investment to their Deemed Asset Value. Operators are also permitted to add the cost of future additions and upgradings of facilities to their Deemed Asset Value. This provision will provide an incentive to operators to reinvest part of their cash flow back into the facility to maintain and improve the level of service provided

by the operator. For clarification purposes, capital expenditures incurred by new beds on line on or after July 1, 1989 during the initial cost reporting period will not be considered as improvements, but as part of actual construction costs.

6) Computation of Cost of Capital

The cost of capital for each patient day served would be calculated for each nursing home based on the Deemed Asset Value. The computation of the rate of reimbursement for the cost of capital is illustrated below in Table 1 for the average facility of 100 beds, based upon federal cost year 1987-1988, which is used for computing state fiscal year rates effective July 1, 1989. In this illustration, the average accumulated depreciation for the industry is used to compute an average Deemed Depreciated Value. Under the plan, each operator will use the accumulated depreciation applicable to his own facility to calculate the Deemed Depreciated Value of his facility. Beginning in federal cost year 1987-1988, which was used for computing state fiscal year 1989-1990 rates, the Deemed Asset Value was set at $23,271 for each bed.

The Deemed Asset Value of the facility would be the fixed $23,271 per bed multiplied by the number of beds, which would amount to $2,327,100 for the average 100 bed facility. To determine the amount of Deemed Depreciated Value for an individual facility, the amount of depreciation costs the provider has reported in accordance with Medicare/Medicaid guidelines would be subtracted from the Deemed Asset Value of the facility and the value of improvements added to the Deemed Asset Value. The average amount of accumulated depreciation for a 100 bed facility is $356,827.

The estimated Deemed Asset Value of the facility less the accumulated depreciation would yield an average Deemed Depreciated Value of $1,970,273 for this average facility. In this example, improvements were assumed to be zero, but an operator would add on the value of any improvements.

At the July 1, 1989 market rate of return of 9.8 percent the annual return would be $193,087. At July 1, 1989, the total capacity of 36,500 patient days for the facility less the two percent turnover factor, would yield a facility capacity factor of 35,770 patient days. Actual patient days will be used if actual occupancy exceeds 98 percent. Effective October 1, 1995, minimum occupancy is established at 97%. This would yield a payment by the State of $5.40 per patient day for each day of Medicaid service. The annual return for the facility will replace facility lease costs and capital interest costs (excluding specialty vehicle interest which is directly charged to the appropriate cost center) reflected under the cost of capital cost center. Lease costs associated with equipment rentals (separate from a facility lease) will be reflected in the affected cost centers.

Table 1

METHOD FOR CALCULATING COST OF CAPITAL REIMBURSEMENT
EFFECTIVE JULY 1, 1989

Original Asset Cost 1980/1981	$ 15,618
Inflation Adjustment to Cost Year 1987-1988	X 1.49
Deemed Asset Value FY 87-88	$ 23,271
Number of Beds	X 100
Deemed Asset Value of Facility	2,327,100
Improvements Since 1981	0
Accumulated Depreciation	(356,827)
Deemed Depreciated Value	1,970,273
Market Rate of Return	X 9.8%
Annual Return for Facility	193,087
Facility @ 98% Capacity*	35,770
Return per Bed per Patient Day	$ 5.40

*Effective October 1, 1995, minimum occupancy is established at 97%.

SC: MA 99-012
EFFECTIVE DATE: 10/01/99
RO APPROVED: 3/10/00
SUPERSEDES: MA 95-018